Suffolk County Department of Social Services
FCSA Child Care Bureau

RELEASE OF CLIENT INFORMATION

This form must be completed and signed by the applicant/recipient IF the applicant/recipient wants DSS to share information regarding their case with a child care provider or advocate/representative, etc. A separate form must be completed for each person that the applicant/recipient wishes to share information with.

I, _____ , _____ , _____
Client Name | Case Number | Date of Birth

Hereby authorize the Suffolk County Department of Social Services to release information that the Department has in reference to my case to:

_____
Name

_____
Street Address

_____
City, State, Zip Code

The Department is authorized to release all information regarding client notices related to eligibility determinations.

This authorization will automatically expire 90 days from signature date unless indicated otherwise here:

_____
Expiration Date

_____
Client Signature

_____
Date

P.O. BOX 18100
HAUPPAUGE, NY 11788-8900

www.suffolkcountyny.gov/departments/socialservices
Child Care Unit Fax #: (631) 854-3331